STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11966254	07/26/2013
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
Good Shepherd Alf, Llc	8610 Nw 24 Court Sunrise, FL 33322	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

List of Tags Cited:
St - A - 0000 - - Initial Comments
St - A - 0010 - 58a-5.0181(4) Fac - Admissions - Continued Residency S-S= G
St - A - 0025 - 58a-5.0182(1) Fac - Resident Care - Supervision S-S= G
St - A - 0030 - 58a-5.0182(6) Fac; 429.28 Fs - Resident Care - Rights & Facility Procedures S-S= D
St - A - 0074 - 58a-5.019(3)(b) - Staffing Standards - Personnel File (bgs) S-S= D
St - A - 0078 - 58a-5.019(2) Fac - Staffing Standards - Staff S-S= D
St - A - 0079 - 58a-5.019(4) Fac - Staffing Standards - Levels S-S= D
St - A - 0161 - 58a-5.024(2) Fac - Records - Staff S-S= D
St - A - Z815 - 408.809, 435.02(2), 435.06 - Background Screening; Prohibited Offenses S-S= C

Specific Tag Findings:

0000-Initial Comments

An Assisted Living Facility complaint inspection survey (CCR# 2013006182 and CCR# 2013007573) was conducted on . . . . and . . . . . Good Shepherd ALF, had licensure deficiencies found at the time of the visit.

0010-Admissions - Continued Residency 58A-5.0181(4) FAC

Based on observation, record review and interview, the facility failed to ensure that 2 out of 6 sampled residents (Resident #1& #3) met the continued residency criteria. The facility also failed to ensure a resident's health assessment (AHCA Form 1823) is updated (completed) after a significant change, for 2 out of 6 sampled residents (Resident #1 & #3) .

The findings include:

Resident #1:
A) Review of Resident #1's hospital records, revealed the following.
1) Resident #1 was admitted to hospital on . . . . with a chief complaint that she had . . . in the facility. No documentation on . . . . . to her sacral and no wounds on both lower legs noted . Resident was discharged back to the facility on . . . .
2) Record review revealed Resident #1 was readmitted to hospital on . . . . with a chief complaint of Change Mental/ . . . . . Status. Record review revealed resident was admitted to the hospital with an un-stageable . . . . . to the sacral. Resident #1 had a . . . . . in place. On . . . . , there was an . . . . of . . . . . with placement of . . . vac.
(Hospital records obtained in addition to photographic evidence)

B) Record review of Resident #1's file, revealed she was admitted to the facility on . . . . and discharged on . . . . . Record review of the residents progress notes show the last entry was from . . . . , which revealed the facility was informed that the resident will be leaving the facility on . . . . , 2013. Record review of Resident #1's health assessment (AHCA Form 1823) dated . . . . revealed the resident poses a threat to self or others. The health assessment also documented the resident requires 24-hour nursing or . . . . care. It was also nothed that the health assessment was not dated by the physician, but dated . . . . by a Registered Nurse on the 5th page. Record review reviewed none of the progress notes nor health assessments accurately document

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the ..... the the sacral of Resident #1. Scanned for documentation.

C) Record review of confidential photographic evidence obtained revealed Resident #1 had a with ..... tissue to the sacral .

D) In an interview with the Administrator on ..... at approximately 12:47 PM, she revealed the following. There was only one lady, Resident #1, that had a redness on her bottom and she was using the cream ..... as well. Resident #1's guardian called her days after she left and said she had pressure sores. She stated she was admitted in and discharged the 22nd of (discharged home). She stated the resident also had a private duty aide. She stated she applied the cream to her area and also put the barrier ointment to her hands and feet. She stated her guardian called her two days before and said she was taking Resident #1 out of the facility. She stated she went to the hospital twice while she was here. The first visit to the hospital was for ..... and the second visit was for chest pains. She stated the heat ..... was only there for a few days.

E) In a phone interview with the guardian of Resident #1 on ..... at approximately 9:22 AM, she stated Resident #1 went home for a few days {after she was discharged from the facility} and then she went to the hospital. She stated it may have been the ..... but does not have her timeline in front of her. She stated she could not get someone out to assess or do ..... l care on the 25th because it was a holiday weekend. She stated that the person that runs the facility told her about the ..... The Administrator took the resident to the doctor on the ..... . She stated nothing had been mentioned to the doctor about it. She stated the Administrator told her that it was just a little scab. She stated they just took the resident to the hospital on Saturday. She stated Resident #1 had an Aide (private duty aide) that was with her from the Wednesday that she brought her from the facility home until she passed.

F) In a phone interview with the home health aide (private duty aide) of Resident #1 on at approximately 11:25 AM, she stated the same day that she picked Resident #1 up from the facility she changed her and noticed the ..... l by the end of her tailbone. She stated she notified the Agency she works for and the guardian. She stated the ..... l was disgusting looking and was draining so it had to be open if it was draining. She stated she picked her up in the morning and took her home from the facility. She stated the resident could not walk and she had to pick her up and put her in the wheelchair because she was pretty weak and could not stand up.

G) In a phone interview with the home health aide of Resident #1 on at approximately 2:43 PM, she stated she started working with Resident #1 on and that is when she took her home and noticed her ..... and notified her employer (the home health agency) and the resident's guardian. She stated the guardian tried to get ..... l care for her but she was not able to get so they ended up taking her to the hospital. She stated it might have been because it was a Friday but the guardian did not want her to wait another day.

Resident #2:
A) The following observations were made of Resident #3 on ..... at approximately 10 AM and 12:35 PM. Resident #3 was observed in ..... # . receiving personal care. The resident was found lying on her right side. The resident had a a ..... in place with amber color of ..... noted in bedside drainage bag. Further observations revealed the resident was unable to turn herself from side to side or assist when in bed. Observations found Resident #3 was dependent with personal care and remained in bed during the duration of the survey.

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B) Record review of Resident #3's record revealed she was admitted to the facility on . . . . . Review of the resident's health assessment (AHCA Form 1823) dated , revealed the resident needs assistance with all activities of daily living (ADL's) except for ambulation in which she was independent. Record review of progress notes, dated , revealed radiation . . . Further record review revealed Resident #3 came from hospital not able to walk due to the pressing on her spine and cause the right hand to be painful. Record review revealed a health assessment form had not been completed after Resident #3 had additional diagnoses as well as being bedridden.

C) In an interview with Staff #3 on . . . . at approximately 12:40 PM, she stated she has to do it for her, if she wants Resident #3 to get out of bed. She stated she is always in her bed and the last time she was out of bed was Tuesday . . . . . She stated she tries to get her up every other day but has to pick her up. She stated Resident #3 needs total help. She stated she gives her a bed bath every morning. She stated resident #3 has been like this since she began working at the facility.

D) In an interview with the Administrator on . . . . . at approximately 12:47 PM, she stated Resident #3 has been living at the facility for a little over two years. She stated she is not on hospice right now. She stated within the last few months Resident #3 has not been able to get out of bed. She stated she was diagnosed with a . . . . . at hospital about two months ago and has been going downhill since then. She stated she washes her in bed and brings her out in the wheelchair and have her sit up and recline; unless she does not want to go out and then they honor her rights. She stated she has been on a . . . . . for two months.

E) In an interview with the Administrator on . . . . at approximately 4:07 PM, she stated that when Resident #3 came back to the facility after she finished up radiation while she was here. She stated they had to take her on a stretcher because she could not walk at this time. She went to the hospital and was walking and when she came back she was no longer able to walk and was complaining of pain down her legs. She stated the pain was one of the reasons they sent her to the hospital. She stated this is when she started doing bed baths. She stated she is still able to feed herself and still able sit her up.

F) In an interview with Staff #1 on . . . . . at approximately 10:00 AM, she stated she has been working at the facility since . . . . . She stated she helps Resident #3 and gives her bed baths, changes her bag, turns her, cleans her, dresses her, gives her medications and gives her meals. She stated she can feed herself. She stated to get her out of bed they have to pick her up and put her in a wheelchair. The resident has been in this condition since she started.

G) In a phone interview with the Nurse Practitioner of Resident #3 on at approximately 11:17 AM, she confirmed that Resident #3 is not able to walk. She stated she cannot lift her lower extremities. She stated Resident #3 needs total help.

H) In a phone interview with the Nurse Practitioner of Resident #3 on at approximately 10:38 AM, she stated she had already spoken to hospice a couple of days before the survey. And when she saw the resident on , she was already paralyzed from the waist down. She stated from , the resident has not been ambulatory. She stated she is not on Hospice yet because the Administrator did not coordinate with the daughter.

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She stated the was placed in originally because she was bedridden and had cloudy due to a She stated that she was bedridden since her lung was discovered about a month before she saw her and due to her condition she is now paralyzed from the waist down but can move her ankles a little.

Class II

0025-Resident Care - Supervision 58A-5.0182(1) FAC

Based on observation, record review and interview, the facility failed to provide care and services appropriate to meet the needs of 2 out of 6 sampled residents (Resident #1, & #3) who were admitted to the facility. The assisted living facility failed to have a written record, updated as needed of any significant changes, for 2 out of 6 (Resident #1, & #3) sampled residents.

The findings include:

Resident #1:
A) Review of Resident #1's hospital records, revealed the following.
1) Resident #1 was admitted to hospital on with a chief complaint that she had in the facility. No documentation on to her sacral and no wounds on both lower legs noted . Resident was discharged back to the facility on
2) Record review revealed Resident #1 was readmitted to hospital on with a chief complaint of Change Mental/ Status. Record review revealed resident was admitted to the hospital with an un-stageable to the sacral. Resident #1 had a in place. On , there was an of with placement of vac.
(Hospital records obtained in addition to photographic evidence)

B) Record review of Resident #1's file, revealed she was admitted to the facility on and discharged on . Record review of the residents progress notes show the last entry was from , which revealed the facility was informed that the resident will be leaving the facility on 2013. Record review of Resident #1's health assessment (AHCA Form 1823) dated , revealed the resident poses a threat to self or others. The health assessment also documented the resident requires 24-hour nursing or care. It was also noted that the health assessment was not dated by the physician, but dated by a Registered Nurse on the 5th page. Record review reviewed none of the progress notes nor health assessments accurately document the the the sacral of Resident #1. Scanned for documentation.

C) Record review of confidential photographic evidence obtained revealed Resident #1 had a with tissue to the sacral .

D) Progress notes dated revealed an appointment for 21 at 2:00 PM with primary doctor. Doctor's office was informed of redness to resident and will look at it at time of visit. Facility is using barrier cream with . Record review revealed the facility failed to properly assess and document the the the of Resident #1. Record review of the physician notes from Resident #1's visit to the doctor on revealed a skin assessment was not completed. Scanned for documentation.

E) In an interview with the Administrator on at approximately 12:47 PM, she revealed the following. There was only one lady, Resident #1, that had a redness on her bottom and she was using the cream

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as well. Resident #1's guardian called her days after she left and said she had pressure sores. She stated she was admitted in and discharged the 22nd of (discharged home). She stated the resident also had a private duty aide. She stated she applied the cream to her area and also put the barrier ointment to her hands and feet. She stated her guardian called her two days before and said she was taking Resident #1 out of the facility. She stated she went to the hospital twice while she was here. The first visit to the hospital was for and the second visit was for chest pains. She stated the heat was only there for a few days.

F) In an interview with the Administrator on at approximately 3:24 PM, she stated that she believes Home Health was discontinued for Resident #1 at this point because [home health company] only gives three or four visits and she would have to call to restart the visits. She stated she did not have a chance to call this time because she was moved out. She stated the guardian sent someone to take her to her doctor's appointment. She stated that it was just redness to her and it was not a She stated the first time she looked at it she put some cream on her

G) In an interview with the Administrator on at approximately 4:10 PM, she stated she believes Resident #1 was using home health services during the month of 2013. She stated she checked on her before she left the facility and only saw redness.

H) In an interview with the Administrator on at approximately 11:05 AM, she stated she checked on the of Resident #1 a couple of days before she left the facility. She stated she put cream on it. She stated it was just redness and there was not an open

I) In an interview with the Administrator on at approximately 12:01 PM, she stated Resident #1 may have had unstageable wounds to her legs. She stated she did not see any open wounds to Resident #1's She stated three days after she was discharged from the facility the guardian of resident #1 called her and told her about the wounds.

J) In a phone interview with the Director of Nursing (DON) from the home health company used in the facility by Resident #1 on at approximately 3:10 PM, she stated they did not have Resident #1 as a patient in 2013. She stated the last time she had Resident #1 as a patient was from to for care to her legs but it heeled.

K) In an interview with the Office Manager from Resident #1's doctor's office on at approximately 10:56 AM, she stated she spoke to the physician's assistant that saw resident #1 and she does remember seeing any wounds during that visit and there were none documented. She stated that prior to that some open wounds were found during her previous visit in but does not believe she took her clothing off to do a skin assessment during this visit.

L) In a phone interview with the guardian of resident #1 on at approximately 9:22 AM, she stated Resident #1 went home for a few days {after she was discharged from the facility} and then she went to the hospital. She stated it may have been the but does not have her timeline in front of her. She stated she could not get someone out to assess or do care on the 25th because it was a holiday weekend. She stated that the person that runs the facility told her about the The Administrator took the resident to the doctor on the . She stated nothing had been mentioned to the doctor about it. She stated the Administrator told her that it was just a little scab. She stated they just took her to the hospital on Saturday. She

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stated Resident #1 had an Aide (private duty aide) that was with her from the Wednesday that she brought her from the facility home until she passed.

M) In a phone interview with the home health aide (private duty aide) of Resident #1 on . at approximately 11:25 AM, she stated the same day that she picked Resident #1 up from the facility she changed her and noticed the . by the end of her tailbone. She stated she notified the Agency she works for and the guardian. She stated the . was disgusting looking and was draining so it had to be open if it was draining. She stated she picked her up in the morning and took her home from the facility. She stated the resident could not walk and she had to pick her up and put her in the wheelchair because she was pretty weak and could not stand up.

N) In a phone interview with the home health aide of resident #1 on . at approximately 2:43 PM, she stated she started working with Resident #1 on . and that is when she took her home and noticed her . and notified her employer and the resident's guardian. She stated the guardian tried to get . care for her but she was not able to get so they ended up taking her to the hospital. She stated it might have been because it was a Friday but the guardian did not want her to wait another day.

2) Resident #2

A) The following observations were made of Resident #3 on . at approximately 10 AM and 12:35 PM. Resident #3 was observed in . # . receiving personal care. The resident was found lying on her right side. The resident had a a . in place with amber color of . noted in bedside drainage bag. Further observations revealed the resident was unable to turn herself from side to side or assist when in bed. Observations found Resident #3 was dependent with personal care and remained in bed during the duration of the survey.

B) Record review of Resident #3's record revealed she was admitted to the facility on . Review of the resident's health assessment (AHCA Form 1823) dated , revealed the resident needs assistance with all activities of daily living (ADL's) except for ambulation in which she was independent. Record review of progress notes, dated , revealed radiation . Further record review revealed Resident #3 came from hospital not able to walk due to the . pressing on her spine and cause the right hand to be painful. Record review revealed a health assessment form had not been completed after Resident #3 had additional diagnoses as well as being bedridden.
Record review of resident #3's record revealed she was admitted to the facility on . Record review of a health assessment (AHCA Form 1823) dated , revealed Resident #3 needs assistance with all activities of daily living (ADL's) except for ambulation in which she was independent. Record review revealed the facility failed to document the . to the sacral of resident #3. Scanned for documentation.

C) In an interview with Staff #3 on . at approximately 12:40 PM, she stated she was applying peri guard cream to Resident #3's sacral area.

D) In an interview with the Administrator on . at approximately 12:45 PM, after being called into , she stated Resident #3 had only a . to her sacral area. The administrator was advised and shown the break in skin on each . She then stated she had not seen the Resident #3 sacral area today and acknowledge the break in skin.

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E) In an interview with the Administrator on [redacted] at approximately 12:47 PM, she stated Resident #3 has been living at the facility for a little over two years. She stated she is not on hospice right now. She stated within the last few months Resident #3 has not been able to get out of bed. She stated she was diagnosed with a [redacted] at hospital about two months ago and has been going downhill since then. She stated she washes her in bed and brings her out in the wheelchair and have her sit up and recline; unless she does not want to go out and then they honor her rights. She stated she has been on a [redacted] for two months. She stated the Nurse Practitioner was here this Monday. She stated she did not leave a note. She stated the Nurse Practitioner comes in and does the [redacted] as well as sees her.

F) In an interview with the Administrator on [redacted] at approximately 10:30 AM, she revealed Resident #3's Nurse Practitioner had gave an order for [redacted] cream to apply to affected area twice a day and as needed. She stated she had not filled the prescription at this point in time. She stated she was currently applying Peri-guard cream.

G) In a phone interview with the Nurse Practitioner of Resident #3 on [redacted] at approximately 11:17 AM, she confirmed that Resident #3 is not able to walk. She stated she cannot lift her lower extremities. She stated resident #3 needs total help.

H) In a phone interview with the Nurse Practitioner of Resident #3 on [redacted] at approximately 10:38 AM, she stated she had already spoken to hospice a couple of days before the survey. And when she saw the resident on [redacted], she was already paralyzed from the waist down. She stated from [redacted] the resident has not been ambulatory. She stated she is not on Hospice yet because the Administrator did not coordinate with the daughter. She stated the [redacted] was placed in originally because she was bedridden and had cloudy [redacted] due to a [redacted]. She stated that she was bedridden since her lung [redacted] was discovered about a month before she saw her and due to her condition she is now paralyzed from the waist down but can move her ankles a little.

Class II

0030-Resident Care - Rights & Facility Procedures 58A-5.0182(6) FAC; 429.28 FS

Based on observation and interview, the facility failed to ensure that 5 out of 5 (Resident #2, #3, #4, #5, #6) current residents were living in a safe and decent living environment and treated with consideration and respect and with the need for privacy.

The findings include:

1) Observations during the course of the survey from approximately 12:05 PM on [redacted] to approximately 1:00 PM on [redacted] found a day bed in between the living [redacted] and the dining [redacted]. Observations found the day bed was approximately 3 feet away from the dining [redacted] in which the residents would eat their meals and approximately 5 feet away from the living [redacted]. Observations found both areas were designated for resident use.

2) In an interview with Staff #3 in the living [redacted] on [redacted] at approximately 12:15 PM, she stated she sleeps at the facility every night from Sunday to Thursday. She stated she is here by herself. She stated she sleeps on the daybed when she puts everybody to bed, so she can see everything. She stated she sleeps right here (point to the location).

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In an interview with the Administrator on at approximately 12:47 PM, she stated all of the staff sleep on the day bed. She stated whenever anybody works they sleep there so they can hear at each end.

In an interview with the Administrator on at approximately 12:01 PM, she acknowledged the findings.

Class III

0074-Staffing Standards - Personnel File (BGS) 58A-5.019(3)(b)

Based on observation, record review and interview, the facility failed to ensure 2 out of 5 (Staff #2, Staff #3) current staff members had the results of employee background screening in their respective personnel files.

The findings include:

1) Record review of Staff #2's personnel record on at approximately 1:10 PM, revealed her personnel file lacked an application and background screening results. Record review of the 2013 and 2013 facility schedule revealed staff #2 was scheduled to work at the facility.

In an interview with the Administrator on at approximately 1:30 PM, she stated Staff #2 will bring in her level II background screening later today. She stated she did not know Staff #2's date of hire.

2) Observations on at approximately 12:05 PM, found Staff #3 was the only staff present at the facility upon entrance.

Record review of Staff #3's personnel record revealed her application was dated Record review revealed Staff #3's personnel file lacked background screening results. Record review of the 2013 and 2013 facility schedule revealed staff #3 was scheduled to work at the facility.

In an interview with the Administrator on at approximately 1:16 PM, she stated she was in the process of getting the background screening from Staff #3. She stated she was background screened but she does not have a copy of it.

3) In an interview with the Administrator on at approximately 1:30 PM, she stated she is having a hard time downloading the background screening results.

Class III

0078-Staffing Standards - Staff 58A-5.019(2) FAC

Based on observation, record review and interview, the facility failed to ensure 2 out of 5 (Administrator, Staff #1) current facility employees had proper verification of freedom from documented.

The findings include :

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1) Record review of the Administrator's personnel record on , revealed her application was dated and her freedom from was dated . Record review revealed the Administrator failed to provide documentation on an annual basis.

2) Observations on at approximately 10:00 AM, found Staff #1 providing personnel care services to Resident #3 in the facility.

Record review of Staff #1's personnel record on , revealed her application was dated and she did not have documentation of freedom from communicable including . Record review of Staff #1's personnel record on , revealed her file contained a freedom from communicable statement dated but still lacked documentation of freedom from .

3) In an interview with the Administrator on at approximately 12:01 PM, she acknowledged the findings.

Class III

0079-Staffing Standards - Levels 58A-5.019(4) FAC

Based on observation, record review and interview, the facility failed to ensure a staff member with documentation of First Aid and training shall be within the facility at all times. The facility failed maintain a written work schedule which reflects its 24-hour staffing pattern for a given time period.

The findings include:

1) Observations on Thursday, , at approximately 12:05 PM, found Staff #3 was the only staff present at the facility upon entrance.

Observations on Thursday, , at approximately 12:35 PM, found the Administrator arrived to the facility.

2) Record review of Staff #3's personnel record on , revealed her application was dated . Record review found that staff #3's personnel record lacked any documentation of having completed trainings related to First Aid and .

Record review of the facility's staff schedule for 2013 revealed both the Administrator and Staff #3 were scheduled to be at the facility from 7:00 AM to 7:00 PM on all Thursdays of the month. Record review of the facility's staff schedule for 2013 found Staff #1 and Staff #3 present and listed as worked at the facility during the month of 2013. Scanned for documentation.

3) In an interview with Staff #3 on at approximately 12:15 PM, she stated the Administrator was there in the morning around 10 AM and stayed for an hour. She stated she just started a month ago. She stated the Administrator comes in for a little while sometimes an hour and sometimes a little more but then she leaves and says she has appointments. She stated she works from Sunday evening from 7:00 PM until Thursday evening at 7:00 PM. She stated she sleeps at the facility every night from Sunday to Thursday. She stated she is there by herself.

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In an interview with the Administrator on at approximately 10:54 AM, she stated that Staff #3 did not have First Aid and in her file. She stated she thought she got it from her because she gave her a list of things to bring in.

In an interview with the Administrator on at approximately 11:05 AM, she stated the 2013 facility schedule was an error. She stated Staff #1 and Staff #3 did not start working at the facility until 2013.

In an interview with the Administrator on at approximately 12:01 PM, she acknowledged the findings.

Class III

0161-Records - Staff 58A-5.024(2) FAC

Based on record review and interview, the facility failed to ensure 1 out of 4 (staff # 2) sampled staff members had an employment application with references furnished. The facility failed to maintain the facility's written work schedules for the last 6 months.

The findings include:

1) Record review of Staff #2 personnel record on revealed the application was not completed by Staff #2. Record review found a blank application in Staff #2's file.

In an interview with the Administrator on at approximately 1:17 PM, she stated staff #2 would come in later to complete the application. She stated she did not know the exact hire date for staff #2.

2) Record review of the facility's staffing schedules revealed 2013 was not available and/or found by the administrator to review.

In an interview with the Administrator on at approximately 11:05 AM, she stated she did not have a schedule for 2013.

3) In an interview with the Administrator on at approximately 12:01 PM, she acknowledged the findings.

Class III

Z815-Background Screening; Prohibited Offenses 408.809, 435.02(2), 435.06

Based on observation, personnel record review and interview, the facility failed to ensure that 1 out of 5 (Staff #1) staff members had a completed a level 2 background screening to provide care to residents.

The findings include:

1) Observations on at approximately 10:00 AM, found staff #1 providing personnel care services to Resident #3 in the facility.

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11966254	07/26/2013
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
Good Shepherd Alf, Llc	8610 Nw 24 Court Sunrise, FL 33322	

SUMMARY STATEMENT OF DEFICIENCIES
(FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)

2) Record review of the facility's staffing schedule found Staff #1 on the schedule for 2013 and 2013 (according to the Administrator, staff #1 was on the 2013 schedule in error).. Record review of Staff #1's personnel file revealed her application was dated . Record review of Staff #1's personnel record lacked a completed level 2 background screening.

Record review of the Agency's background screening website on revealed Staff #1 was determined to be eligible on and had a permanent hire date of .

3) In an interview with Staff #3 on at approximately 12:15 PM, she stated she works from Sunday evening 7:00 PM to Thursday evening 7:00 PM. She stated Staff #1 relieves her. She stated Staff #1 is there on Sunday and she relieves her.

In an interview with the Administrator on at approximately 2:50 PM, she stated staff #1 started working at the facility on She stated that Staff #1 sleeps at the facility at night and that she (the Administrator) is in and out. She stated she does not sleep there when staff #1 sleeps there. She stated she just took her background screening Monday {of this week} and is coming this evening for the slip for her to download. She stated each staff pays for their own background screening. She stated she did not have a background screening completed before so she asked her to go and get it done. She stated she believed that she had thirty days from her start date to get her background screened.

In an interview with Staff #1 on at approximately 10:00 AM, she stated she has been working at the facility since . She stated she is a home health aide and did not work for another facility before this. She stated she did the background screening on Monday (of that week). She stated she gave the paperwork to the Administrator and she needs to look up the results. She stated she slept at the facility last night and was the only staff member there. She stated she comes on Thursdays of each week at 6:30 PM and gets off Sundays at 6:30 PM. She stated she has had the same schedule and duties, since she began working there and works by herself. She stated she cooks, cleans, changes them, gives medications and assists in every area they need help.

In an interview with the Administrator on at approximately 12:01 PM, she acknowledged the findings.

Unclassified

AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2013

Good Shepherd ALF, LLC
Administrator
8610 NW 24th Court
Sunrise, Florida 33322

Dear Administrator,

This letter reports the findings of a complaint inspection survey (CCR# 2013006182 and CCR# 2013007573) conducted on . 2013 and . 2013, by representatives of the Agency for Health Care Administration. Attached is the provider's copy of the Statement of Deficiencies, which indicates there were deficiencies noted during the inspection. You are hereby responsible for complying with the Agency's corrective action plan within **five calendar days** of receipt of this hand delivered report.

The inspection resulted in findings of non-compliance in the following areas:

1) A0010- Admission- Continued Residency- Class II
The Assisted Living Facility failed to ensure all residents met continued residency criteria. The facility failed to ensure residents with a significant change in condition have a face to face medical examination documented on an AHCA Form 1823.

2) A0025- Resident Care- Supervision- Class III
The Assisted Living Facility failed to provide the care and services to meet the needs of every resident. The facility failed to document all significant changes.

3) Z815- Background Screening; Prohibited Offenses- Unclassified
The Assisted Living Facility failed to ensure all direct care staff were eligible for employment prior to providing direct care to residents.

Directed Corrective Actions:

1) The Assisted Living Facility is required to ensure that Resident #3 undergo an immediate face to face medical examination documented on an AHCA Form 1823. If it is determined that Resident #3 does not meet criteria, the facility must make arrangements for a higher level of care.
2) The Assisted Living Facility is required to ensure that all residents undergo an additional face to face medical examination documented on an AHCA Form 1823. The Assisted Living Facility is responsible for ensuring that the attending physician be familiar with 58A-5.0181(4) F.A.C.

to ensure all residents meet continued residency criteria. If the resident is not determined to meet criteria, the facility must make arrangements for a higher level of care.

3) The Assisted Living Facility must ensure all current and future residents have an AHCA Form 1823 dated on or after . 2013.
4) The Assisted Living Facility shall audit and maintain all resident files to ensure all appropriate documentation is available.
5) The Assisted Living Facility shall be required to maintain progress notes/documentation for each resident on a daily basis to ensure appropriate care and services are rendered to each resident as physician order (until A 0025 is corrected by the Agency). The facility from correction date must ensure all residents are provided care and services as physician order.
6) The Assisted Living Facility shall maintain an accurate monthly staffing schedule, identifying hours worked for each staff member (including the Administrator) on a daily basis. Any changes to the staffing hours, must be immediately updated on the staffing schedule.

7) The Assisted Living Facility shall ensure all current and future employees have an eligible level 2 background screening. All employees with a level 1 background screening must be rescreened.
8) The Assisted Living Facility shall ensure all background screening results be maintained in each employees file.

Please be advised that nothing in this DPOC limits the Agencies authority and responsibility to impose administrative sanctions as provided by law.

Should you have any questions, please call Tikel Wedges-Phoenix, Health Facility Supervisor or Catherine Anne Avery, Survey and Certification
Support Branch, at 850-412-4505.

Regards,

Arlene Mayo-Davis, Field Office Manager